Consent to Treatment

I/we**, _____,** the undersigned, hereby provide consent for counseling services provided by **Brightway Counseling and Wellness**. I understand that all counselors with **Brightway Counseling and Wellness** hold required professional licenses to provide counseling services.

Licensed Professional Counselor (LPC) and a Licensed Professional Counselor Associate (LPCA) is a counselor holding at least a master's degree in Counseling or Psychology. **LPC Associates** have completed all required internships and clinical practicums and are supervised by a Licensed Professional Counselor Supervisor for 3000 clinical hours.

Fees- ***Fees are due at the time of service. Charge permission forms are provided for recurring sessions.***
LPC - Initial intake appointment - $135.00; sessions 50 min- $125.00
LPC Associate - Initial Intake appointment - $75.00; sessions 50 min - $75.00

Insurance- Insurance policies may require only a co-pay or co-insurance for sessions. I agree to assign insurance benefits to ***Brightway Counseling and Wellness*** **for any insurance plan my counselor is in network.**

I accept financial responsibility for charges I/we incur during treatment (initial) _____.

Please initial each statement below:

_____I understand that appointment times are reserved, and a **$50.00** fee will be charged for appointments missed or cancelled without a 24-hour notice.

_____I give permission for **Brightway Counseling and Wellness** to disseminate necessary information to affiliated Business Associates and a HIPAA compliant practice management web-based program for the purposes of maintaining clinical records, scheduling and billing.

_____I have read and received a copy of **Privacy Practices** and the Use and Disclosure of Personal Health Information for **Brightway Counseling and Wellness**.

_____I understand that if my counselor is subpoenaed for deposition, testimony or any other court appearance, **Brightway Counseling and Wellness** will bill me **$1000.00 per day** of attendance.

_____I understand there are confidentiality limitations when communicating via text, phone and email. If I choose to communicate with my therapist via text, phone and/or email, I understand that this information could be obtained by an unintended third party.

_____I choose to allow communication with my therapist in the following manner: Please initial and include information.
_____Telephone text/number: _____
_____Email:_____

_____I understand I may revoke this consent at any time by giving written notice to **Brightway Counseling and Wellness.**

_____I/we understand that results or outcomes from the therapy process cannot be guaranteed.

_____I/we understand that we can question any therapeutic approach utilized at any time. If I/we decide to terminate therapy; I/we will discuss termination with the therapist. Complaints can be filed with the Texas State Board of Licensed Professional Counselors at (800) 821-3205.

Print Name of Client: _____

Print Name of Parent/Guardian
(if Client is under 18 years old) _____

Signature of Client or Parent/guardian: _____